Vogtle 2
3Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Sep 27, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Provide a Suitable Reactor Vessel Vent Results in Inaccurate Reactor Vessel Level Indication
A self-revealing NCV was identified for failure to maintain a suitable reactor vessel vent path which resulted in inaccurate reactor vessel water level indication and lower than expected reactor vessel level.

This finding was greater than minor because it affected the initiating events cornerstone objective of configuration control of shutdown equipment. The finding determined to be of very low safety significance because all of the equipment, procedures, and policies that are expected to be maintained in the five shutdown safety functional areas were met.
Inspection Report# : 2003004*(pdf)*

Significance: G Apr 05, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Chemical Control Procedures Results in Excessive Steam Generator Sodium Concentrations and Dual Unit Forced Shutdowns
Failure to follow chemistry control procedures resulted in the wrong corrosion control chemicals being added to the feedwater systems on both units and the unplanned forced shutdown of Unit 1 and Unit 2 to Mode 5, Cold Shutdown, due to high sodium concentrations in both units' feedwater systems.

A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified. This finding is greater than minor because it affected the initiating events cornerstone objective by causing a perturbation of plant secondary side chemistry resulting in the unplanned forced shutdown of both units. The finding is of very low safety significance because the consequence of the chemical addition error was limited to the unplanned forced shutdown of both units. The direct cause of this finding involved the cross-cutting area of Human Performance.
Inspection Report# : 2003002*(pdf)*

Significance: G Apr 05, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Power Ascension Procedure Results in Manual Reactor Trip
Failure to follow operations startup procedures resulted in a steam generator water level transient and manual reactor trip during transfer of feedwater level control to the Main Feedwater Regulating Valves.

A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified. This finding is greater than minor because it affected the initiating events cornerstone objective by causing a perturbation in plant stability that resulted in

a manual reactor trip. The finding is of very low safety significance because it had no other consequence other than resulting in a reactor trip. The direct cause of this finding involved the cross-cutting area of Human Performance.
Inspection Report# : 2003002*(pdf)*

Mitigating Systems

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Reactivate Part 55 Licenses in Accordance with Procedure
A non-cited violation was identified for the failure of multiple Part 55 licensees to reactivate Reactor Operator and Senior Reactor Operator licenses in accordance with procedure 10010-C, Operator Qualification Program, Revision (Rev) 2.

This finding is greater than minor because it is associated with human performance attributes of license reactivation that affect operational safety. The finding was evaluated using the Operator Requalification Human Performance SDP (IMC 0609 Appendix I) and determined of very low safety significance because more than 20 percent of the reactivation records reviewed failed to meet the requirements.
Inspection Report# : 2003004*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Risk Assessment For Reduced Vessel Level Conditions
A NCV of 10 CFR 50.65(a)(4) was identified for failure to properly assess and manage the increase in risk of RCS level instrumentation unavailability during a Unit 2 RCS leak repair shutdown outage.

The failure to properly assess risk following changes to planned availability of RCS level instrumentation was greater than minor because it affected the configuration control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events (such as a loss of RCS inventory in reduced level conditions). The finding was determined to be of very low safety significance because all of the equipment, procedures, and policies that are expected to be maintained in the five shutdown safety functional areas were met.
Inspection Report# : 2003004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: SL-IV Dec 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Falsification of Security Access Control System Records
A Severity Level IV, non-cited violation of 10 CFR 50.9 was identified for the failure to maintain the results of a drug screening test and the associated entry in the licensee's Access Control System database complete and accurate in that the site Fitness-for-Duty Coordinator deliberately altered information indicating a specimen was negative for drugs when it was, in fact, positive for marijuana and amphetamines.

Because this issue involved willfulness on the part of a licensee employee and inaccurate information which impacts the regulatory process, it was not subject to the provisions of the Reactor Oversight Process, and was dispositioned in accordance with traditional enforcement. The finding was determined to be greater than minor because a barrier was lost in the physical security system in that the failure to properly categorize and report a positive drug test result had the potential to allow unescorted plant access to an individual who did not meet access requirements.
Inspection Report# : 2002004*(pdf)*

Miscellaneous

Significance: N/A Jan 03, 2003
Identified By: NRC
Item Type: FIN Finding
Biennial Problem Identification and Resolution Inspection
Overall, the licensee's Corrective Action Program (CAP) was effective at identifying, evaluating, and correcting problems. The threshold for entering problems into the CAP was low, resulting in a large number of Condition Reports (CRs). Problems entered into the CAP were adequately evaluated and appropriate actions were taken to resolve the problem. Recent events, including two reactor trips during low power feed water operations, and a dual unit shutdown due to secondary chemistry problems, were caused in part by human performance errors combined with weak supervisory oversight. The licensee is currently addressing these common root causes and developing corrective actions.

Some instances of missed problem identification were noted. System engineers were found to use the CAP effectively to address equipment issues. Quality Assurance organization audits were effective in identifying issues. Self-assessments were appropriate and findings were entered into the CAP. A safety conscious work environment was found where employees felt free to raise safety issues in CRs or the employee concerns program.
Inspection Report# : 2002005*(pdf)*

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